



PacAdvantage
Choice • Simplicity • Affordability

EMPLOYEE/MEMBER OPEN ENROLLMENT CHANGE FORM

Please complete this form and return it to your employer. If you seek services prior to receiving your ID card from the plan, you may be required to pay out-of-pocket costs for care received. These out-of-pocket costs may be reimbursed by the plan, if they are part of your covered benefits.

REQUIRED INFORMATION (for all changes)

Group Number

Name of Employer

Salutation

Mr. Mrs. Ms.

First name _____ Last name _____ M.I. _____ Suffix (Jr., Sr., etc.) _____

Social security number _____ Date of birth _____ / _____ / _____

IN THIS SECTION, COMPLETE ONLY THE INFORMATION THAT HAS CHANGED.

Home phone number _____ / _____ / _____ Home fax number _____ / _____ / _____

Physical home address

Apartment _____ City _____

State _____ Zip _____ Martial status
 Single Married Other

Mailing address

Apartment _____ City _____

State _____ Zip _____ E-mail address _____

IF YOU WISH TO CHANGE THE COVERAGE CHOICE FOR YOUR BENEFIT PACKAGE, PLEASE INDICATE BELOW.

If you are disenrolling a dependent, have your company representative confirm this information with pacadvantage.

COVERAGE CHOICE

Employee only Employee and spouse/domestic partner Employee and child(ren) Family

Children under age 2 are not covered for dental vision, or chiropractic/acupuncture benefits unless you specially request it.

If you wish to add dependents to your benefit package, you must also complete the dependent application forms which were included in your group's enrollment package.



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Social security number

_____ - _____ - _____

MEDICAL PLAN SELECTION

Are you waiving medical coverage? Yes No (Refer to the Employee Handbook for more information.)

PLAN NUMBER **SELECTED PARTICIPATING HEALTH PLAN NAME**

PRIMARY CARE PHYSICIAN/MEDICAL GROUP ID NUMBER

CO-PAYMENT/DEDUCTIBLE OPTION (HMO only)

Preferred Plus Standard

Are you a current patient? Yes No

Primary care physician's last name

Primary care physician's first name

(To verify provider availability, contact selected medical/dental carrier.)

Dependent's name

Dep. primary care physicians last name

Dep. primary care physicians first name

DENTAL PLAN SELECTION (if applicable)

PLAN NUMBER **SELECTED PARTICIPATING DENTAL PLAN NAME**

DENTIST/DENTAL GROUP ID NUMBER

Are you a current patient? Yes No

Dentist's last name

Dentist's first name

(To verify provider availability, contact selected medical/dental carrier.)

Dependent's name

Dependent's dentist's last name

Dependent's dentist's first name

VISION PLAN SELECTION (if applicable)

PLAN NUMBER **SELECTED PARTICIPATING VISION PLAN NAME**

VISION CO-PAYMENT OPTION Preferred Plus

CHIROPRACTIC/ACUPUNCTURE PLAN SELECTION (if applicable)

IS YOUR EMPLOYER ELECTING THIS BENEFIT OPTION? Yes No

PLAN NUMBER **SELECTED PARTICIPATING CHIROPRACTIC/ACUPUNCTURE PLAN NAME**

CHIROPRACTIC/ACUPUNCTURE CO-PAYMENT OPTION Standard Plus

SIGNATURE OF EMPLOYEE REQUIRED

Signature _____

Date signed _____ / _____ / _____